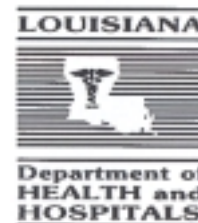




# Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section  
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## Outbreak of Gastroenteritis at a School

On Tuesday, March 28, 2000, the Louisiana Office of Public Health was notified that a school in central Louisiana had an unusually high number of children with gastrointestinal illness the previous Friday, March 24, 2000. Of the 357 enrollees (pre-K – grade 12), 103 (29%) did not attend school on March 24. In addition, some teachers and administrative staff also had symptoms of gastrointestinal illness.

All ill and non-ill children in grades 4, 7, 8, 9, 10, 11 and 12, as well as ill teachers, were interviewed at the school on March 29 and 30. Phone interviews were conducted with the parents of children in grades three and below who were absent on March 24. A total of 171 questionnaires were completed.

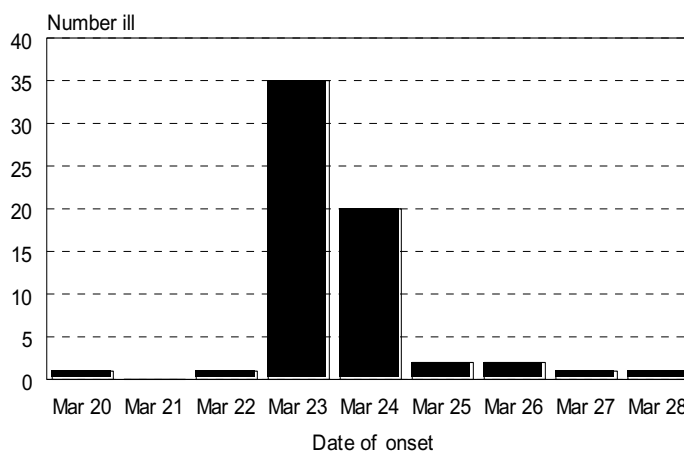
Of the 81 respondents who reported illness, 56 persons met the case definition. Vomiting, nausea, and abdominal cramping were the most commonly reported symptoms (Table 1). Most of those questioned had an onset of March 23 or 24 and were ill for a duration of 24 hours or less (Figure).

**Table 1:** Frequency of symptoms among cases, March 23-24, 2000\*  
(n = 56)

Symptom	Number ill	%
Nausea	53	98.1
Fatigue	52	96.3
Vomiting	50	90.9
Abdominal cramping	48	85.7
Diarrhea	38	67.9
Fever	35	64.8
Headache	32	59.3
Joint pain	17	31.5
Cough	7	13.5

\*Case defined as having diarrhea or vomiting and onset on 3/23 or 3/24.

**Figure:** Date of illness onset among cases, March, 2000



It was found that a special event had occurred on March 23 – Grandparents Day. Elementary and junior high students were joined by as many as 100 grandparents in the gymnasium for lunch. The same menu was provided and the same handlers prepared the meal. Volunteers did not help prepare the meal on March 23, but did help serve the meal. They were identified but not interviewed. While no grandparents were personally interviewed, the 5 to 10 children questioned about their grandparents being ill answered that they had not been ill.

Five food handlers were interviewed and stool cultures were obtained. All food is prepared on site on the day that it is served. All children without special nutritional needs eat in the cafeteria, during one of three shifts. It is typical for all staff to eat the meal served in the cafeteria. During a routine inspection on March 9, 2000 the sanitarian identified the need for the installation of a working hand lavatory. This matter had not yet been resolved at the time of the outbreak.

The first person ill, who could not remember if onset was on Monday, March 20 or Tuesday, March 21, was a lunch worker. Her responses as to whether she was ill and when she was ill changed among three interviews. Given other evidence and the circumstances of each interview, it does seem that an onset of March 20 or March 21 may be the most accurate.

In calculating the relative risk associated with each food item, the following case definition was used: vomiting or diarrhea with onset on March 23 or 24 and in the 4<sup>th</sup> grade or older (Figure). Wednesday's lunch had an infinite relative risk (Table 2). Having eaten Wednesday's lunch was defined as having eaten jambalaya or bread. Similarly, eating Thursday's lunch was defined as having eaten red beans or bread. Of the individual food items, jambalaya (Continue on next page)

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## Outbreak of Gastroenteritis at a School (Cont.)

had the highest relative risk. The p-value was not significant, but the population was not very large.

Eight stools were cultured to rule out the most common bacterial causes of gastroenteritis. All stools were negative for salmonella, shigella, campylobacter, and vibrio. While Norwalk virus was suspected, the specimens were inadequate for testing.

**Table 2:** Food items served at school, March 22-23, 2000\*

Food	Ate		Did not eat		RR
	Ill	Not ill	Ill	Not ill	
<b>Wednesday (3/22) lunch</b>	40	96	0	4	undefine
Jambalaya	38	87	2	13	2.28
Coleslaw	12	12	28	89	2.07
Peach cobbler	18	29	22	70	1.60
Bread	35	86	5	14	1.10
Milk	32	72	8	28	1.38
Water	12	31	26	67	1.00
Ice	0	0	25	60	
<b>Thursday (3/23) lunch</b>	38	82	1	8	2.85
Red beans	32	65	8	35	1.77
Rice	32	71	8	29	1.44
Sausage	29	69	9	30	1.28
Applesauce	11	32	29	67	0.85
Green salad	23	62	14	37	0.99
Milk	31	75	9	24	1.07
Water	9	30	24	62	0.83
Ice	0	0	21	54	1.00
Bread	29	64	5	17	1.37
Italian dressing	7	10	30	88	1.62
Ranch dressing	14	40	23	58	0.91
Thousand Island dressing	2	5	35	93	1.04

\*This Table does not include students below the 4<sup>th</sup> grade (due to unreliability of food history) or those with onset of illness prior to 3/23.

Based on the incubation period of Norwalk-like virus, and food handlers' interviews, the index case of this outbreak was likely a food handler and this may have contributed to the outbreak illnesses among the school children. The lunch served on Wednesday, March 22<sup>nd</sup> was statistically significant in association with illness, in which jambalaya may have been the primary vehicle.

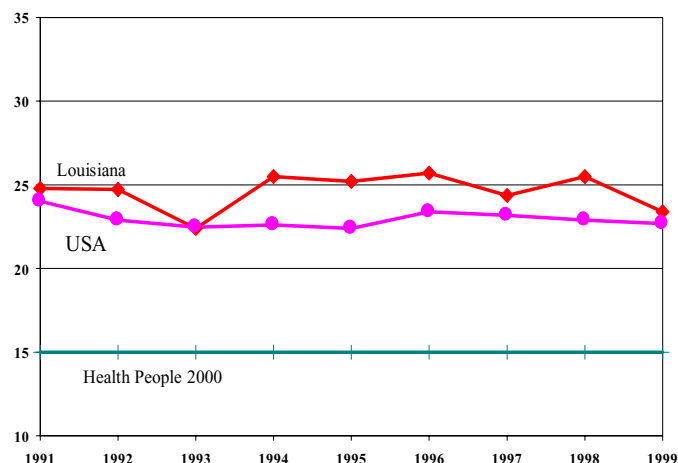
It was recommended to the school that food handlers' activities should be restricted for a week to ten days if they have diarrhea or vomiting from the gastrointestinal illness. The school was also advised to install a working hand lavatory as soon as possible.



## BRFSS: Tobacco Trends in Louisiana, 1991-1999

Louisiana remains in the top 25% of states for the percentage of adults who report current cigarette smoking. Approximately one-fourth of Louisiana adults were current cigarette smokers during the time period 1991-1999. From 1998-1999, overall cigarette smoking prevalence appears to be declining (Figure 1).

**Figure 1:** Prevalence of current smoking, LA vs USA, Louisiana, BRFSS 1991-1999



Cigarette smoking is the leading cause of preventable death in Louisiana. Smoking accounts for 1 out of 5 deaths both in Louisiana and the U.S. It results in more deaths each year than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle accidents, and fire when combined.

Data on self-reported cigarette smoking among adults (18 years and older) in Louisiana is available from 1991-1999 from the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an ongoing statewide surveillance system that collects data on self-reported behaviors and conditions. An average of 1650 adults was interviewed each year.

For the purposes of this report, a current cigarette smoker is defined as an individual who has ever smoked 100 cigarettes and now smokes every day or some days. A former smoker is defined as an individual who has ever smoked 100 cigarettes and now does not

### Louisiana Morbidity Report

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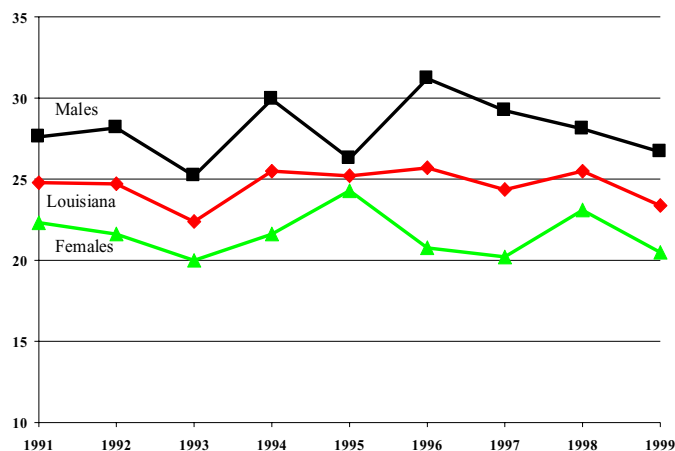
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**Figure 2:** Prevalence of current smoking by gender, Louisiana, BRFSS 1991-1999

smoke every day or some days and a never smoker is an individual who has never smoked at least 100 cigarettes.

Smoking prevalence is consistently higher for males than females (Figure 2). This gender difference is found both in African Americans and Whites. The prevalence of current smoking among males has decreased since 1996, while rates for females have remained relatively stable. On average, there is no difference in smoking prevalence between Whites and African-Americans. In both groups, cigarette smoking prevalence appears to be declining.

From 1991-1999, approximately 56% of Louisiana adults are never smokers and 21% are former smokers. Forty-five percent of males are never smokers and 26% are former smokers compared to 62% of women who are never smokers and 17% who are former smokers. African Americans have higher never rates (64.1%) and lower former smoking rates (13.2%) compared to Whites (49.6% and 24.5% respectively).

Other characteristics related to current smoking are outlined in the Table. In 1999 the highest current smoking prevalence group is among persons aged 18-44. There is a strong inverse relationship between current smoking and income and educational level. As education and income increase, the percentage of current smoking decreases.

The National Center for Health Statistics *Healthy People 2000* goal is to reduce the prevalence of cigarette smoking to 15% among adults aged 20 and older. Louisiana remains far away from this goal, and has consistently reported a higher prevalence of current smoking than the national median.

The Louisiana Office of Public Health, Tobacco Control Program is a prevention and control program with the goal of preventing and reducing tobacco use and tobacco-related diseases. The program is focused on environmental and policy changes through the following strategies: community based interventions, partnerships, and collaboration among agencies, groups, programs, families, and health care professionals. For more information, contact Ms. Diane Hargrove-Roberson, Tobacco Control and Prevention Program, (504) 568-3596.

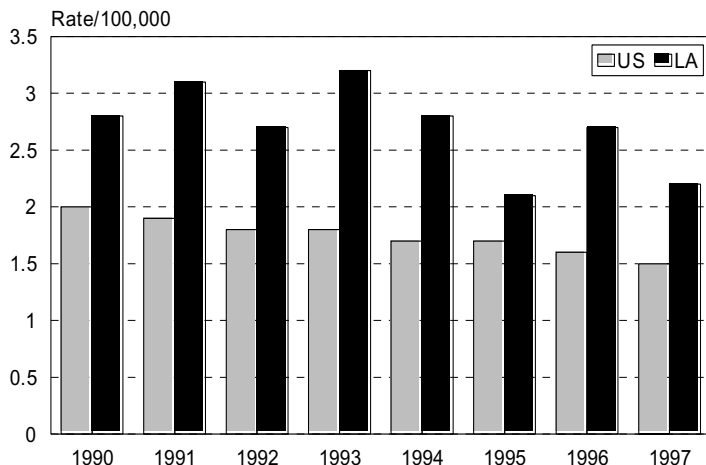
Table 1: Cigarette smoking indicators, adults 18 years and older, Louisiana, BRFSS 1999 (N=1670)

Groups	TOTAL	Current Smoker		Former Smoker		Never Smoker	
		Weighted (adjusted) Rate		Weighted (adjusted) Rate		Weighted (adjusted) Rate	
		#	%	#	%	#	%
<b>TOTAL</b>	<b>1670</b>	<b>383</b>	<b>23.4</b>	<b>340</b>	<b>20.6</b>	<b>942</b>	<b>55.7</b>
<b><u>Sex</u></b>							
Male	663	179	26.7	161	23.5	321	49.4
Female	1007	204	20.5	179	18.0	621	61.3
<b><u>Age</u></b>							
18-24	182	52	28.7	15	7.6	113	62.3
25-44	684	188	28.5	82	11.9	413	59.6
45-64	479	114	22.2	113	29.8	230	47.8
65+	315	29	9.6	107	36.7	179	53.7
<b><u>Education</u></b>							
Less than High School	293	76	28.0	60	21.2	156	49.9
High School Graduate	590	158	27.4	111	18.6	318	53.7
Some College	386	95	24.3	78	20.6	213	55.2
College Graduate	398	54	12.9	89	22.9	254	64.1
<b><u>Income</u></b>							
< \$15,000	244	64	30.7	35	12.7	145	56.6
\$15,000-\$24,999	341	83	24.9	70	20.4	186	54.3
\$25,000-\$49,999	482	119	24.9	102	22.5	260	52.5
≥ \$50,000	361	71	19.2	81	22.5	208	58.1
<b><u>Race</u></b>							
White	1118	267	24.6	275	25.2	573	50.0
African-American	442	91	19.5	42	9.3	307	70.4

## Fatal Fire and Burn Injuries

The fire and burn injury death rate in Louisiana has exceeded the US rate every year from 1990 through 1997, the most recent year in which national data are available (Figure).

**Figure:** Fire and burn injury death rates, US and Louisiana, 1990-1997



The fire and burn death rate for Louisiana in 1998 was 2.3 per 100,000 population. Eighty-seven fires resulted in 101 Louisiana residents sustaining a fatal fire or burn injury. Males died at a slightly higher rate than females (2.5 vs. 2.1 per 100,000). Blacks were more than twice as likely to die as whites (3.7 vs. 1.6 per 100,000, RR=2.3,  $p < .001$ ). Though deaths occurred across the age spectrum for whites and blacks, blacks were more likely to die at younger ages than whites (median: 35 years vs. 53 years). Young black children

(aged < 5 years) represent 3% of the population, however they sustained 13% of all fire and burn deaths in 1998.

Region 6 (the Alexandria area) had the highest death rate, 3.9 per 100,000, followed by Region 8 (the Monroe area) with a rate of 3.5 per 100,000. Each of the seven remaining regions had a rate below 3.0 per 100,000.

Ninety percent (88 cases) of all fatal fire and burn injuries were sustained in residential fires. According to the National Fire Prevention Association, cooking, careless use of cigarettes, improper use of heating equipment and improper use of electrical equipment are the leading sources of ignition in most residential fires.

The CDC National Center for Injury Prevention and Control, along with other fire prevention advocacy groups, recommends that all households install and maintain a working smoke alarm on every level of the home and near each sleeping area. Smoke alarm batteries should be replaced at least once every year. Smoke alarms should be checked once a month to assure they are functioning properly. Data collected in 1998 via the Behavioral Risk Factor Surveillance System, a telephone survey based on a random sample of adults, indicated that 48% of Louisiana residents interviewed said it had been more than 1 month since they had deliberately tested all of the smoke alarms in their home. Eleven percent said there were no smoke alarms in their home.

In conjunction with maintaining an adequate number of smoke alarms in homes, families should discuss at least two ways to escape from every room of the home. The escape plan should be practiced every six months.

Based on the high number of fire-related deaths in black children, additional prevention activities should be targeted to this group.

### CONFIDENTIAL DISEASE CASE REPORT

All diseases and conditions on the list of reportable diseases (see the back of this report) should be reported on an EPI-2430 card (below), or on other forms as stated. Please print out this form and forward reports by fax or mail to either the local parish health unit or to the Infectious Disease Epidemiology Section, Department of Health & Hospitals, Office of Public Health, P.O. Box 60630, New Orleans, LA 70160. The phone numbers are 504-568-5005 or 1-800-256-2748 or FAX 504-568-5006. All facsimile transmissions are considered part of the confidential disease case report, and as such, are not subject to disclosure. Xerox additional copies as needed. Your support in disease reporting will enhance disease surveillance activities.

DISEASE/CONDITION		DATE OF REPORT		DATE OF ONSET	
PATIENT'S NAME		RACE*	ETHNIC**	SEX	DATE OF BIRTH
ADDRESS	STREET NO. (R.F.D. If rural)			ZIP CODE	
	CITY		PARISH		
HEAD OF HOUSEHOLD			PHONE NO.		
DAY CARE CENTER ASSOCIATED: YES ___ NO ___			DATE		SPECIMEN TYPE
NAME OF DCC:					
LAB RESULTS					
COMMENTS:					
PHYSICIAN/HOSPITAL				PHONE NUMBER	

\*Wh = White, not of Hispanic origin, Bl = Black, Pac Is/Asi = Pacific islander or Asian, Am Ind/AI = American indian or Alaskan Native

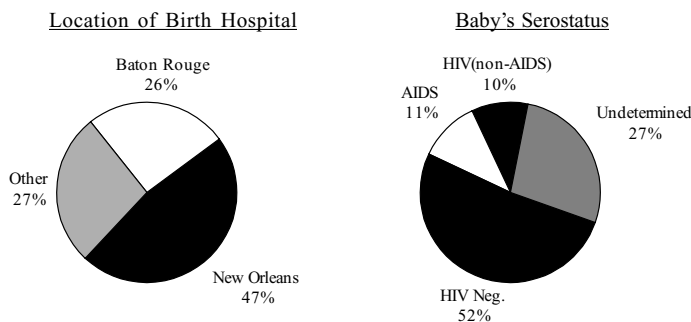
\*\* Hisp/Non-Hispanic

## HIV/AIDS Update

### New Efforts to Reduce Perinatal HIV Transmission in Louisiana

**Scope of Perinatal Transmission Risk in Louisiana:** Through August of this year, 1,179 cumulative cases of children born to HIV-infected mothers have been reported in Louisiana. At least 21 percent of the exposed children have developed HIV or AIDS (Figure 1). However, the widespread adoption of the prophylactic zidovudine (ZDV) regimen has resulted in a significant decline of mother-to-child transmission of HIV in recent years (Figures 2 and 3). While a three-part regimen of ZDV can reduce perinatal transmission to approximately 8 percent,\* the success of the intervention is dependent upon women obtaining appropriate prenatal care, being screened for HIV, and receiving the medications.

**Figure 1:** Babies born to HIV-infected mothers, Louisiana  
1,179 cumulative cases



**Grant from CDC:** The Louisiana Office of Public Health HIV/AIDS Program was recently awarded a supplemental grant from the Centers for Disease Control and Prevention to strengthen efforts towards eliminating perinatal transmission of HIV. The program will involve clinician education, implementation of rapid HIV-testing in delivery centers, media and outreach targeting women of childbearing age, and strengthening links between prenatal, pediatric, HIV medical care, and supportive services.

**Recommendations for Clinicians:** The Perinatal HIV Prevention Program seeks to promote the following recommendations for all clinicians providing prenatal and obstetric care:

Universal HIV screening as a part of routine prenatal care for *all* women, with consent;

Rapid HIV-testing of women who present at labor and delivery with no prenatal care or no documented HIV test during the current pregnancy, with consent;

Access to the ZDV regimen for women who are HIV-infected and pregnant, including those women who present at labor and delivery with no previous care;

Counseling HIV-infected mothers to avoid breastfeeding;

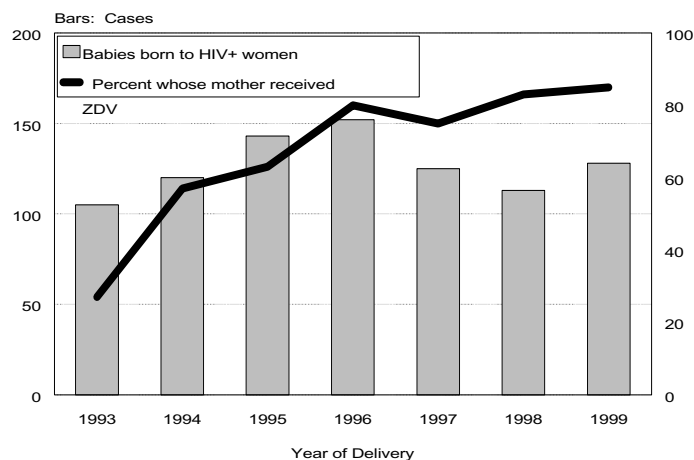
Referrals to link HIV-infected women with statewide programs that can help with access to medication, transportation to prenatal and medical appointments, food, financial assistance with housing and insurance, as well as other medical and supportive services.

The Perinatal HIV Prevention Program will coordinate in-ser-

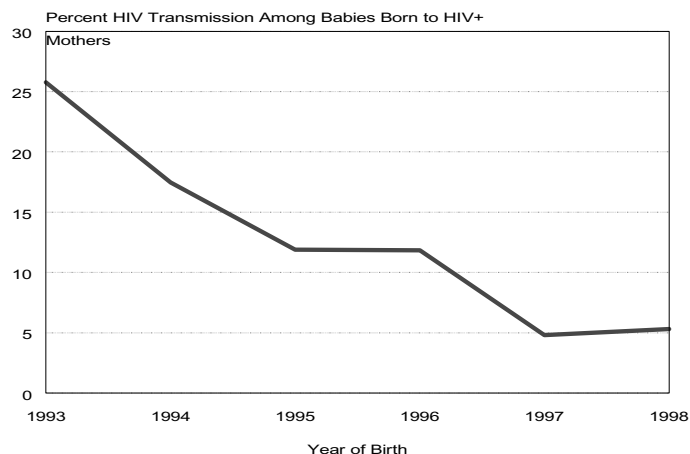
vice trainings for prenatal and pediatric providers as needs are identified or requested. For more information about the grant activities or the supportive services available around the state to help people with HIV, please contact Amy Zapata, MPH—Perinatal HIV Prevention Coordinator at the HIV/AIDS Program, (504) 568-7474.

*\*U.S. Public Health Task Force Recommendations for the Use of Anti-Retroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States. February 25, 2000*

**Figure 2:** ZDV (AZT) use in HIV + pregnant women



**Figure 3:** Perinatal HIV transmission rates



#### HIV Resources for Clinicians

**Delta AIDS Education and Training Center—(504) 568-3855**

*Clinical consultation warmline, clinical training programs, resource library, newsletter*

**National HIV/AIDS Warmline—(800) 933-3413**

*Clinical consultation warmline*

**HIV/AIDS Treatment Information Service**

[www.hivatis.org](http://www.hivatis.org)

*Clinical treatment guidelines*

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE  
July - August, 2000  
**PROVISIONAL DATA**

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD				
	1	2	3	4	5	6	7	8	9	Jul-Aug 2000	Jul-Aug 1999	Jan-Aug Cum 2000	Jan-Aug Cum 1999	% Chg
<b>Vaccine-preventable</b>														
<i>H. influenzae</i> (type B)	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	6	1	1	0	1	0	0	0	0	9	25	81	126	-35.7
Rate <sup>1</sup>	0.6	0.2	0.3	-	0.4	-	-	-	-	0.2	0.6	1.9	2.9	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	0	0	0	0	0	0	3	4	7	-42.9
Rubella	0	0	0	0	0	0	0	0	0	0	0	1	0	-
Pertussis	2	1	2	0	0	0	0	0	0	5	4	12	9	+33.3
<b>Sexually-transmitted</b>														
HIV/AIDS Cases <sup>2</sup>	62	29	4	8	2	11	8	5	4	133	228	670	878	-24
Rate <sup>1</sup>	6.0	5.3	1.1	1.6	0.8	3.5	1.6	1.4	1.1	3.2	5.4	15.9	20.8	
Gonorrhea Cases	661	332	108	217	81	102	483	283	166	2434	2324	8794	8482	+3.7
Rate <sup>1</sup>	63.6	58.5	28.6	42.1	30.2	33.4	95.5	80.6	43.1	57.7	55.1	208.4	201.0	
Syphilis (P&S) Cases	6	8	10	19	6	1	0	0	1	51	74	145	200	-27.5
Rate <sup>1</sup>	0.6	1.4	2.7	3.7	2.2	0.3	-	-	0.3	1.2	1.8	3.4	4.7	
<b>Enteric</b>														
Campylobacter	1	0	0	2	2	0	0	0	1	6	28	68	92	-26.1
Hepatitis A Cases	8	0	0	0	0	0	1	0	1	10	70	48	148	-67.6
Rate <sup>1</sup>	0.8	-	-	-	-	-	0.2	-	0.3	0.3	1.6	0.9	3.4	
Salmonella Cases	4	6	9	12	9	3	8	5	9	66	133	237	316	-25
Rate <sup>1</sup>	0.4	1.1	2.4	2.3	3.4	1.0	1.6	1.4	2.3	0.9	3.1	2.6	7.3	
Shigella Cases	2	0	3	0	2	1	3	1	4	16	33	130	112	+16.1
Rate <sup>1</sup>	0.2	-	0.8	-	0.7	0.3	0.6	0.3	1.0	0.4	0.8	2.0	2.6	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	3	0	-
Vibrio, other	1	0	0	1	1	0	0	0	0	3	5	19	19	-
<b>Other</b>														
<i>H. influenzae</i> (other)	3	0	0	0	0	0	0	0	0	3	0	11	11	-
<i>N. Meningitidis</i>	3	1	0	0	0	0	0	0	0	4	5	32	50	-36
Tuberculosis	20	0	5	4	6	0	6	1	0	42	27	164	151	+8.6

1 = Cases Per 100,000

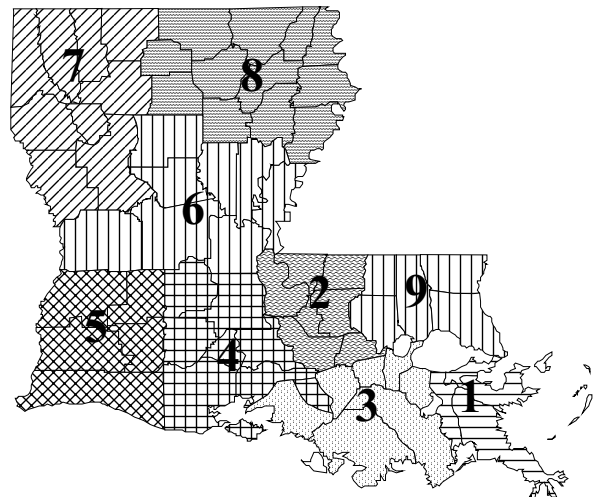
2=These totals reflect persons with HIV infection whose status was first detected during the specified time period. This includes persons who were diagnosed with AIDS at time HIV was first detected.

**Table 2. Diseases of Low Frequency**

Disease	Total to Date
E.coli 0157:H7	9
Lead Toxicity	4
Legionellosis	6
Lyme Disease	3
Malaria	7
Rabies, animal	5
Varicella	82

**Table 3. Animal Rabies (July-August, 2000)**

Parish	No. Cases	Species
Claiborne	1	Bat
St. Landry	1	Skunk



## ANNUAL SUMMARY

### Salmonellosis- 1999

In 1999, 718 cases of salmonellosis were reported, a 17% decrease from 1998 (864; Figure 1). Sex-specific rates were higher for males than females (17.2 vs 16.0 per 100,000, respectively). Sex-race specific rates per 100,000 were highest in White females (12.2), followed by White males (11.5), Black males (11.1) and Black females (9). The 0-4 years age group represented 50% of the cases. Seventeen case-patients were reported to be associated with day care centers, and none of these were outbreak related. Reported cases by month of onset began to increase during the summer months and peaked in September (Figure 2). Parishes reporting the highest case rates per 100,000 were St. Tammany (47) and Washington (46). Of the 36 identified serotypes for *Salmonella*, the three most frequently isolated were *S. newport* (5.8%), *S. enteritidis* (4%) and *S. typhimurium* (3.7%) (Table). Two cases of *S. typhi* (Typhoid fever) were identified, both of which were associated with international travel.

Figure 1: Cases of salmonellosis by year, 1990-1999

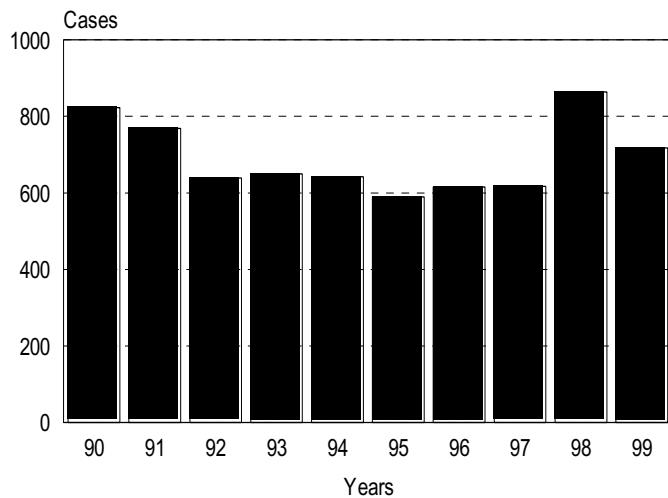
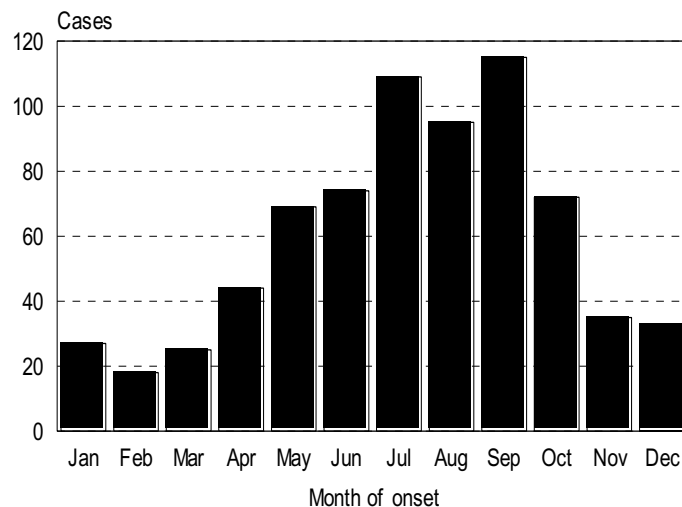


Figure 2: Cases of salmonellosis by month of onset, 1999



#### Comments:

Salmonellosis is usually transmitted to humans either by person-to-person contact or through the consumption of food or water contaminated with animal feces or raw egg. Foods contaminated with *Salmonella* usually look and smell normal, and are often of animal origin, but all foods have the potential to become contaminated. In fact, in 1999, there were several national product recalls of salmonella-contaminated fruits and vegetables. Infection may be prevented through thorough cooking of foods, and prevention of contact of other foods with raw foods of animal origin. Careful handwashing is also important, as foods may become contaminated from an infected food handler who neglected to wash his or her hands after using the bathroom.

*Salmonella* infections usually resolve in 5-7 days and often do not require treatment unless the patient becomes severely dehydrated or the infection spreads from the intestines. Persons with severe diarrhea may require rehydration, often with intravenous fluids. Antibiotics are not usually necessary unless the infection spreads from the intestines. Unfortunately, some *Salmonella* bacteria have become resistant to antibiotics.

*Salmonella* may also be found in the feces of some pets, especially those with diarrhea, and people can become infected if they do not wash their hands after contact with their pets. Reptiles are particularly likely to harbor *Salmonella* and people should always wash their hands immediately after handling a reptile, even if the reptile is healthy.

Table: Frequency of salmonella serotypes, 1997-1999

Serotype	1997 cases	1997 rank	1997 %	1998 cases	1998 rank	1998 %	1999 cases	1999 rank	1999 %
<i>newport</i>	95	1	21	117	1	14	42	1	6
<i>enteritidis</i>	25	4	6	25	5	4	29	2	4
<i>typhimurium</i>	92	2	20	99	2	15	27	3	4
<i>javana</i>	24	5	5	78	3	12	14	4	2
<i>montevideo</i>							14	5	2
<i>mississippi</i>	42	3	9	65	4	10	12	6	2

#### Louisiana Fact

Prior to 1800, organized public health programs were uncommon. However, chiefly because New Orleans was notoriously susceptible to epidemics, Louisiana established a Board of Health nearly a decade and a half before similar action was taken by any other state. The Board had a tenuous existence at first, but it attained permanent status within a few years through public appreciation of its accomplishments. State control of the Board of Health was maintained except during the four years following the occupation of New Orleans during the Civil War. Source: *The Formative Years*, by Gordon E. Gillson

# LIST OF REPORTABLE DISEASES/CONDITIONS

## REPORTABLE DISEASES

## OTHER REPORTABLE CONDITIONS

Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis, Acute (A, B, C, Other)	Rubella (German measles)	Cancer
Amebiasis	Hepatitis B carriage in pregnancy	Rubella (congenital syndrome)	Complications of abortion
Arthropod-borne encephalitis (Specify type)	Herpes (neonatal)	Salmonellosis	Congenital hypothyroidism*
Blastomycosis	Human Immunodeficiency Virus (HIV) infection <sup>3</sup>	Shigellosis	Severe traumatic head injury**
Botulism <sup>1</sup>	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Galactosemia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Hemophilia*
Chancroid <sup>2</sup>	Lymphogranuloma venereum <sup>2</sup>	Syphilis <sup>2</sup>	Lead Poisoning
Chlamydial infection <sup>2</sup>	Malaria	Tetanus	Phenylketonuria*
Cholera <sup>1</sup>	Measles (rubeola) <sup>1</sup>	Tuberculosis <sup>4</sup>	Reye's Syndrome
Cryptosporidiosis	Meningitis, other bacterial or fungal	Typhoid fever	Severe under nutrition (severe anemia, failure to thrive)
Diphtheria	Mumps	Varicella (chickenpox)	Sickle cell disease (newborns)*
Enterococcus (infection; resistant to vancomycin)	Mycobacteriosis, atypical <sup>4</sup>	Vibrio infections (excluding cholera) <sup>1</sup>	Spinal cord injury**
Escherichia coli 0157:H7 infection	Neisseria meningitidis infection <sup>1</sup>		Sudden infant death syndrome (SIDS)
Gonorrhea <sup>2</sup>	Pertussis		Traumatic Brain Injury
Haemophilus influenzae infection <sup>1</sup>	Rabies (animal & man)		
Hemolytic-Uremic Syndrome	Rocky Mountain Spotted Fever (RMSF)		

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, phone reports, or electronic transmission.

<sup>1</sup> Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.

<sup>2</sup> Report on STD-43 form. Report cases of syphilis with active lesions by telephone.

<sup>3</sup> Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.

<sup>4</sup> Report on CDC 72.5 (f. 5.2431) card.

All reportable diseases and conditions other than the venereal diseases, tuberculosis and those conditions with \*'s should be reported on an EPI-2430 card and forwarded to the local parish health unit or the Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160, Phone: 504-568-5005 or 1-800-256-2748 or FAX: 504-568-5006.

\* Report to the Louisiana Genetic Diseases Program Office by telephone (504) 568-5070 or FAX (504) 568-7722.

\*\* Report on DDP-3 form; preliminary phone report from ER encouraged (504-568-2509). Information contained in reports required under this section shall remain confidential in accordance with the law.

## Numbers for reporting communicable diseases

**1-800-256-2748**

**Local # 568-5005**

**FAX # 504-568-5006**

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